FINAL 11/06

STATE OF LOUISIANA

MEDICATION ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In most instances, medications will be administered by unlicensed personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name _____ Birthdate _____

School _____ Grade _____

Parent or Legal Guardian Name (print): _____

Parent or Legal Guardian Signature:_____ Date:_____

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Relevant Diagnosis(es): _____
2. Student's General Health Status: _____
3. Medication: _____
4. Strength of medication: _____ Dosage (amount to be given): _____

   Check Route: ❑ By mouth ❑ By inhalation ❑ Other _____

   Frequency _____ Time of each dose _____

   _____

   School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.
5. Duration of medication order: ❑ Until end of school term ❑ Other _____
6. Desired Effect: _____
7. Possible side-effects of medication: _____
8. Any contraindications for administering medication: _____

   _____
9. Other medications being taken by student when not at school:

   _____

   _____
10. Next visit is: _____

_____

Prescriber's Name (Printed) Address Phone and Fax Numbers

_____

Prescriber's Signature Credential (i.e., MD, NP, DDS) Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medications orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE.

Inhalants / Emergency Drugs

Release Form for Students to be Allowed to Carry Medication on His/Her Person

Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration training? ❑ Yes ❑ No
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ❑ Yes ❑ No
3. If training has not occurred, may the school nurse conduct a training program? ❑Yes ❑ No

_____

Licensed Provider's Signature Date

BEAUREGARD PARISH SCHOOL BOARD
Parent/Guardian Request for Medication Administration as School
(THIS SIDE TO BE COMPLETED BY GUARDIAN)

Student: _____ **Date of Birth:** _____ **Sex: M** ☐ **F** ☐

School: _____ **Grade:** _____ **Name of Parent/Guardian:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____

STUDENT ALLERGIES: (List medication, food, insects, latex, etc.) _____

Other person(s) to be notified in case of emergency when parent(s)/Guardian(s) are unavailable

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Parent/Guardian's Consent

1. I hereby give permission for the school nurse or his/her trained designee to administer medication at school, by giving the following, _____ to my above named child, prescribed by _____.
   (Medication, Dose, Route, Frequency) (Physician Name)

2. I give permission to the school nurse to communicate with my child's doctor and school personnel regarding my child's medication administration as necessary for my child's health and safety. YES_____ NO_____
   Restrictions on release: _____.

3. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following termination of the medication order or one week beyond the end if the current school term.
   YES_____NO_____

4. I have administered the initial dose ordered at home and have allowed a minimum of 12 hours for observation of adverse reactions before asking school personnel to administer the medication. YES_____NO_____

5. I realize that I am responsible to deliver the medication to the school, in and original prescription bottle with a date after July 1st of the current school year, which is labeled with the child's name, doctor's name, name of medication, dosage, route, specific time of administration, Pharmacist's name, RX number, and containing no more than a 30-day supply. YES_____NO_____

6. My Child's physician/pharmacist has discussed to my understanding all potential side effects and adverse reactions, as well as how to administer the prescribed medication. YES_____NO_____

7. In the event my child's physician has ordered a medication at a higher dose that the manufacturer's recommended dosage, I understand and accept the responsibility and liability, as well as, I relieve the school board and its employees from any liability.
   YES☐ NO_____

8. I understand that it is the parent/guardian's responsibility to notify the school nurse and school of any changes to my child's medication(s) and/or medical condition(s). YES_____NO_____

ALL ANSWERS MUST BE YES BEFORE THE MEDICATION MAY BE CONSIDERED FOR ADMINISTRATION AT SCHOOL

If applicable: Consent for Management of Diabetes at School

To be Completed by Parent/Guardian:

I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following Management of Diabetes in school be administered to our (my) child in accordance with state laws and regulations.
I will: 1. Provide the necessary supplies, equipment, and snacks.
2. Notify the school nurse if there is a change to the pupils' health status or attending Authorized Health Care Provider.
3. Notify the school nurse immediately and provide a new consent for any changes in the doctor's orders.
I authorize the school nurse to communicate with the Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual Health Care Plan upon request.

Name Parent/Guardian: _____ **(Please print)**

Signature of Parent/Guardian _____ **Date** _____

Relationship to student: _____ **RX Number** _____